Consecutive Treatment. The first point to be attended to is the ligature or torsion of vessels; and when only a small number of vessels have required to be tied or twisted after an amputation of one of the large limbs or after extirpation of a tumour involving a great loss of substance, M. Guersant advises that the dressing should be delayed for half an hour or an hour after the operation. He says he has always followed this plan with advantage. This precept, which was given by Dupuytren, has the advantage of allowing time for the re-establishment of the circulation, and obviates the necessity of removing the dressings to arrest hemorrhage which has come on after the application. If it be necessary, after certain operations, to plug the wound with perchloride of iron, this should be well diluted with water, to avoid sloughing.

M. Guersant, following the advice of Dupuytren and Lisfranc, almost always renews the dressings on the day after the operation. The removal of the charpie and lint, the bandages and sutures not being interfered with, prevents the danger of many accidents. Erysipelas is prevented, by the removal of charpie impregnated with blood and serosity; pus, if it have formed, is allowed to escape from between the lips of the wound; and if the edges of the wound have been strangulated by the sutures being too numerous or drawn too tight, they can be removed or loosened. If there be erysipelas, M. Guersant has often seen benefit derived from the application of collodion. This, with the internal use of tincture of aconite, sometimes prevents purulent absorption—a very rare accident in children, but which occasionally occurs.

If the wound become pale and gray, the application of charpie, soaked in solution of chlorinated soda is very useful; and the application of pure lemon juice has, in M. Guersant's hands, given a healthy aspect to an unhealty looking wound.

General treatment is often of still more importance than local treatment. Usually, if there be no convulsions (an accident which rarely occurs even after the most severe operations), or if there be no special contraindications, a nutritious diet should be allowed from the day of operation. Whenever it is possible, infants should be put to the breast from the first day, rather than be fed from a bottle; they should be allowed to suck as much as they desire, at intervals of two hours. For other children, the food should at first be liquid, and consist of milk and beef-tea; after the first day wine may be given. A return should be gradually made to the child's original food, to which may sometimes be added chocolate, coffee, quinine, and other tonics. This regimen is indispensable, unless consecutive internal disease set in and demand on the part of the surgeon the amount of medical knowledge necessary for detecting and properly treating them—without which there is no success in surgery. We must, M. Guersant says, never forget that the operator must be a physician before operation, a surgeon during the performance, and again a physician to terminate and even to bring to a successful issue many surgical operations.

Finally, all the means which have been here described may fail, if the hygiene of the patients be neglected. Thus, all things being otherwise equal, children who are operated on in the town in the homes of parents in good circumstances, and who reside in well ventilated and warmed rooms, according to the indications of the case, are in better condition for recovery than those who are operated on in hospitals, where numerous patients are collected in one room, of which the air is, in spite of all that can be done, more or less vitiated.

—

24. *Tracheotomy and its Employment in Diphtheria.*—Mr. Henry Smith read before the Medical Society, London (Oct. 19, 1863), a paper on this subject. He commenced by referring to the different manner in which tracheotomy was estimated in the present day compared with some years since, and quoted the words of Sir Charles Bell, who stated in his work on Operative Surgery that he had never once performed the operation. Of late years it had taken a high place in our surgical means, and had proved very successful in saving life in instances where death would otherwise have speedily resulted; and surgical writers now spoke with confidence of it, instead of treating the subject with doubt and hesitation. Even in croup the operation, which a few years since was hardly deemed warranted in this disease, had latterly been so successful

that it might be recommended in certain instances with confidence; but it was in reference to inflammatory affections of the throat in the adult that he was going to call their attention to it, for it had been found that in such cases the operation was eminently successful. After alluding to the various diseases of the throat and air-passages in which tracheotomy was applicable, Mr. Smith drew particular attention to two conditions wherein the operation was most useful and most beneficial. The first referred to was that state where there had been for some time a chronic inflammation of the larynx going on, and then a sudden aggravation threateniug death from suffocation had taken place. Here tracheotomy, if well executed and not put off to late, would prove emineutly successful. Some very interesting cases were related as illustrations. The other form of disease was one in which there had been syphilitic mischief in the throat for some period, and a sudden attack of dyspnœa had come on. Here also tracheotomy would be eminently successful, and that in two ways; for it would not only immediately arrest death, but time would be allowed for the introduction of those remedies into the system which would counteract the syphilitic poison, and thus cure the disease. A very successful case of this kind was narrated.

The author then made especial reference to the use of the laryngoscope in iustances where tracheotomy was performed, stating its great value as a means of determining the exact nature of the disease in the larynx, and thus showing when and how far an operation was called for. A laryngoscopic examination was also especially useful in cases where the operation had been performed, for by it we should be able to learn the progress of the case; and more especially would this examination assist us in deciding the question as to the removal of the tube—often a very difficult thing to decide. Cases were mentioned by the author wherein the use of the laryngoscope had been attended with great advantage both before and after the operation.

With regard to the employment of tracheotomy in diphtheria, Mr. Smith admitted at once that this was a difficult and unsatisfactory question; for, although the operation had been tried on many occasions, the want of success attending it had been so marked as to lead us to put little faith in it. The reasons for this want of success were considered at some length. The most obvious one in his opinion was, that the patient was suffering, not from a local complaint, but from a highly poisoned state of the blood; so that even if relief were given for a period by the introduction of air, the patient would sooner or later relapse into his former poisoned condition. He had been called to cases in which, for this reason, he had refused to operate; and he was sorry to say that in those cases where he or his personal friends had performed trachcotomy in diphtheria, death had almost invariable resulted. Nevertheless, if there was the least chance of the operation saving life, he thought it should be performed; and that there was this chance was proved by a case narrated lately by Dr. Hillier, where undoubtedly the patient—a member of the medical profession—was snatched from the jaws of death by the operation, performed when he was rapidly sinking from diphtheria.

Mr. Smith concluded his paper by some observations on the best mode of performing tracheotomy. In the last paper which he had read before this Society, he had considered the dangers and difficulties of the operation somewhat fully, and the best mode of meeting them. After having had a large experience of this operation at every age and under every condition, he was inclined to the opinion that tracheotomy was thought too lightly of by many, especially by those who had merely made themselves acquainted with it in the anatomical theatre or deadhouse. For his own part, he had often met with great difficulties in its performance; and he believed the best way of avoiding them was to use the simplest instruments—viz., a sharp scalpel and a hook, to abjure all those injurious contrivances which were intended to facilitate the operatiou; and, above all, taking due care to get out of the way of important parts, to cut rapidly down upon the trachea instead of making a slow and cautious dissection. —*Lancet*, Oct. 24, 1863.

25. *Mucous Cyst on the Laryngeal Aspect of the Epiglottis, seen by the Laryngoscope and successfully treated by Incision.*—Mr. A. E. DURHAM related to the